EFFECTIVE JANUARY 1, 2007

EMPLOYEE ENROLLMENT GUIDE

Understanding Your Health Coverage

Washington State
Health Care Authority
Public Employees Benefits Board

HCA 50-100 (12/06)

Contact the Plans

If you want additional information about PEBB coverage or to update your account, call a benefits specialist toll-free at 1-800-200-1004, Monday through Friday, 8 a.m. to 5 p.m., or visit our Web site at **www.pebb.hca.wa.gov**.

Medical Plans	Web site address	Customer service phone numbers	TTY Customer service phone numbers (deaf, hard of hearing, or speech impaired)
Community Health Plan Classic	www.chpw.org	206-521-8830 or 1-800-440-1561	1-800-833-6388
Group Health Classic and Value	www.ghc.org/pebb	206-901-4636 or 1-888-901-4636	711 or 1-800-833-6388
Kaiser Permanente Classic and Value	www.kaiserpermanente.org	Portland: 503-813-2000 All other areas: 1-800-813-2000	1-800-735-2900
Regence Classic	www.wa.regence.com/pebb	1-800-376-7926	253-573-3464
Uniform Medical Plan	www.ump.hca.wa.gov	1-800-762-6004 or 425-670-3000	1-888-923-5622 or 360-923-2701

Dental Plans	Web site address	Customer service phone numbers
DeltaCare, administered by Washington Dental Service	www.deltadentalwa.com/pebb.htm	1-800-650-1583
Regence BlueShield Columbia Dental Plan	www.wa.regence.com/pebb	1-800-376-7926
Uniform Dental Plan	www.deltadentalwa.com/pebb.htm	1-800-537-3406

Contact the plans for help with:

- Specific benefit questions.
- Choosing a doctor or dentist.
- To verify if your doctor or other provider contracts with the plan.
- Drug formulary.
- I.D. cards.
- Claims.

Contact your employer for help with:

- Changing your name, address, and phone number.
- Finding forms.
- Adding/removing dependents.
- Payroll deduction information.

Contact PEBB for help with:

- Eligibility questions and changes (Medicare, student, divorce).
- Eligibility complaints/appeals.
- Payment information.

Blue ink indicates information only for subscribers who have dental coverage.

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To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Glossary

Allowed charges

The maximum amount your insurance plan will pay for covered services, treatments, or supplies.

Annual deductible

The amount you must pay each calendar year before the plan pays benefits for covered expenses. Most plans described in this guide do not have an annual deductible, except the value managed-care plans, the Uniform Medical Plan (UMP), and the **Uniform Dental Plan (UDP)**. Some benefits may not apply to the annual deductible. Refer to your plan's certificate of coverage for details.

Annual out-of-pocket maximum

The most you would pay toward the majority of covered expenses in a calendar year. Once you've reached your out-of-pocket maximum, the plans pay 100 percent of most covered expenses for the rest of the calendar year. For most medical plans, these expenses apply to the out-of-pocket maximum:

- Inpatient hospital admissions.
- Ambulance service.
- Outpatient/day surgery and ambulatory surgery centers.
- Physical, occupational, speech, and massage therapy.
- Organ transplants.
- Skilled nursing facility services.

Value managed-care plans and the UMP have higher out-of-pocket limits than classic managed-care plans, and the **Uniform Dental Plan has higher out-of-pocket limits than the managed-care dental plans.** Refer to your plan's certificate of coverage for details.

Certificate of coverage

A legal document that describes eligibility, covered services, limitations and exclusions, utilization procedures, and other plan provisions. The medical or **dental plan** will provide you with a certificate of coverage after you enroll.

Certificate of creditable coverage

A legal document that verifies that you had health coverage during a specific period.

Coinsurance

The percentage you pay on claims for when your plan pays benefits at less than 100 percent.

Copay

The fixed cost you pay for services at the time you receive care. Most plans described in this guide require copays (sometimes called a "copayment") when you see network providers or receive prescription drugs.

Drug formulary

(Some plans call this a preferred drug list.) A list of approved prescription drugs that the plan will cover. Each plan has a different formulary. Contact the plans for details.

Emergency

Conditions with symptoms so severe that most people would reasonably expect that, without immediate health care attention, the condition would:

- Seriously jeopardize the individual's physical or mental health.
- Seriously impair bodily functions.
- Cause a serious dysfunction of any body organ or part.

Your plan has the right to determine whether the symptoms indicate a medical emergency. See the plan's certificate of coverage for details.

HCA

The Health Care Authority (HCA) is the state agency that develops and administers health insurance programs for state and higher-education employees, retirees, and their dependents, as well as other eligible groups that choose to purchase Public Employees Benefits Board (PEBB) coverage. The HCA provides medical, **dental**, life, and long-term disability insurance coverage to eligible enrollees through the PEBB program. PEBB enrollees receive their benefits through private health plans that contract with the HCA, and the self-insured Uniform Medical Plan **and Uniform Dental Plan.** The PEBB is responsible for designing and approving benefits and eligibility for public employees, retirees, and their dependents, in accordance with state and federal laws.

Hospice care

Medical, therapeutic, nursing, or counseling services for a terminally ill patient and family enrollees by a public or private agency or organization for that specific purpose.

Inpatient

An enrollee who has been admitted to the hospital, receives inpatient room and board services, and is expected to remain 24 hours or longer.

Maximum plan payment for medical plans

The total amount paid out by each PEBB-sponsored medical plan, except Medicare supplement plans, on behalf of each covered individual for all benefits, is limited to a lifetime maximum plan payment of $2,000,000. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the plan during the prior calendar year. Some services also have specific calendar year or lifetime benefit limitations, as detailed in each plan's certificate of coverage.

Network

A group of health care providers in a certain geographic location (including doctors, hospitals, and other health care professionals and facilities) who have contracted to provide services to a health plan's members at negotiated rates.

Open enrollment

The period of time each year when you may change medical **and/or dental plans** and add eligible dependents to your coverage without providing proof of previous coverage. Changes begin January 1 of the following year.

Outpatient

A patient who receives covered services inside or outside a health care facility under a provider's direction, but is not admitted as an inpatient.

Premium

The monthly amount PEBB enrollees pay for the cost of their health insurance. Premiums vary in cost depending on the health plan and the number of family members covered.

Primary care provider (PCP)

The doctor or nurse you choose to see for regular office visits, and who may refer you to and coordinate your care with specialists.

Some PEBB managed-care plans require each enrollee to have a primary care provider, who may be in family practice, internal medicine, or pediatrics. For some plans, women may choose obstetricians or gynecologists for their PCP. However, each covered family member may have a different PCP. If you do not choose a PCP, some plans will choose one for you based on where you live. You may change your PCP during the year. The list of providers may be updated periodically.

Provider

A health care practitioner or facility operating within the scope of a license.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Subnetwork

A provider group (such as hospitals, physicians, specialists, and other providers) whose members may restrict your choice of referred specialists to only those within that same provider group.

Welcome

The Washington State Health Care Authority (HCA) is the agency that purchases and coordinates health insurance benefits for public employees through the Public Employees Benefits Board (PEBB) program. This guide provides you (the subscriber) with some basic information about your medical or your medical **and dental** coverage and will help you in making your health plan decisions.

If you are a state agency or higher-education employee, you have medical and dental coverage. If you are employed by a school district, county or city government, or other employer group, your employer may offer medical only or medical and dental. Check with your payroll, personnel, or benefits office to learn what coverage your employer offers.

The benefits described in this guide are brief summaries. For a complete description of PEBB benefits, refer to the plan's certificate of coverage. (See the "Glossary" for definition.) You will receive your certificate of coverage directly from your plan after you enroll.

Some benefits described in this guide are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

You may find the Public Employees Benefits Board's existing laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at slc.leg.wa.gov.

Public Employees Benefits Board Members

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Margaret Stanley
Benefits Management/
Cost Containment

Yvonne Tate*
Benefits Management/
Cost Containment

*Non-voting member

Blue ink indicates information only for subscribers who have dental coverage.

How to Enroll

If your employer offers medical *and* dental, you must choose a medical plan and a dental plan when you fill out your enrollment form. State agencies and higher-education institutions offer dental coverage but some school districts, city and county governments, and other employer groups do not. Please check with your payroll, personnel or benefits office.

Follow these steps to choose a plan:

1. Check "Plans Available by County" in this guide to find which medical plans are offered in your county.
2. Gather information.
   a) Read about the different types of medical and **dental** plans PEBB offers. Descriptions of the medical plans begin on page 17. **If your employer offers dental coverage, also read description of the dental plans on page 37.** Call the plans directly with questions about specific benefits, drug formularies, or provider participation. The health plan phone numbers and Web addresses are listed at the front of this guide.
   b) Compare the health plans' monthly premiums on page 18 **(there is no employee contribution for dental coverage).**
   c) Check the provider directory on the PEBB Web site at **www.pebb.hca.wa.gov** to find out if your provider participates with the medical plan you choose. Then call the plan directly to confirm your doctor's participation. If you are choosing a doctor or other health care provider for the first time, be sure to find out if he or she is accepting new patients.
3. Choose your medical **and dental plan (if your employer offers dental coverage)**. There are no restrictions or waiting periods for preexisting conditions under any of the PEBB medical or **dental plans**. You must enroll all eligible family members in the same medical **and/or dental plan**. However, each family member may have a different doctor or other health care provider.
4. If you enroll family members, complete the appropriate certification form(s) when required.
5. Complete the enrollment form and return it to your personnel, payroll, or benefits office **within 31 days** after the date you become eligible to apply.

If you don't submit an enrollment form within 31 days after you become eligible for health benefits, we will enroll you in the Uniform Medical Plan (UMP) as a single subscriber. If your employer offers dental coverage and you fail to enroll within 31 days, we will also enroll you in the Uniform Dental Plan as a single subscriber. However, claims for benefits will be denied until you submit a completed enrollment form. Your next opportunity to change plans or add dependents will be the next open enrollment period. For exceptions, refer to pages 12-14.

Flexible Spending Account

Washington Flex is a medical flexible spending account (FSA) program that allows insurance-eligible state and higher-education employees to set aside money from each paycheck—before taxes—to pay for out-of-pocket health expenses.

If you want to set up an FSA, you must enroll **within 31 days** after you become eligible or wait until the next annual open enrollment period.

You decide how much you want to contribute per pay period when you enroll. (The minimum annual contribution is $240; the maximum is $2,400.)

The full amount of your calendar year FSA contribution is available after you enroll. You may use your FSA to reimburse yourself for out-of-pocket medical, dental, and vision expenses allowed by the Internal Revenue Service (IRS). You may not pay premiums from your account, but you can use it for deductibles, copays, and coinsurance. Your own expenses and those of family members who qualify as dependents under IRS rules may be reimbursed from your account.

Application Software, Inc. (ASI) is our 2007 FSA administrator. For more information and forms, go to ASI's Washington Flex Web site at **www.asiflex.com/pebb** or call ASI at 1-800-659-3035. Send questions via e-mail to **asi@asiflex.com.**

I.D. Cards

After you enroll, your plan will send you an identification (I.D.) card to show to providers when you receive care.
If you have questions about your I.D. card, contact your plan directly.
(The Uniform Dental Plan does not issue identification cards.)

Questions and Answers

Covering Dependents

Are my family members eligible?

If you are enrolling yourself, you may also enroll your legal spouse or qualified same-sex domestic partner and eligible children. See the "Dependents" section on page 12 for the definition of eligible dependents.

Are there additional forms required to enroll my dependents?

You must complete a certification form (available on PEBB's Web site or from PEBB Benefit Services) if you want to add any of the following:

- A spouse or qualified same-sex domestic partner.
- A student over age 19.
- A dependent over age 19 with a disability.
- An extended (legal) dependent.

See "Dependents" on page 12 for eligibility and certification form requirements.

One of my children attends college. Can I still enroll in a managed-care plan not offered in the county where he or she goes to college?

Yes. If your dependent(s) lives outside your plan's service area temporarily while attending an accredited secondary school, college, university, vocational school, or school of nursing, he or she may receive benefits through any licensed provider. Claims for those providers will be paid as if the service had been received through plan-designated providers. Refer to your plan's certificate of coverage (COC) for details. Your dependent will be responsible for the same copayments or coinsurance amounts that apply to enrollees who receive services in their plan area. However, the plan must authorize routine care and all other services in advance, except when emergency or urgent care is needed.

If I die, can my surviving dependents continue PEBB coverage?

Yes. See "Options for Continuing Coverage" on page 15 for details. Dependents who waived coverage prior to your death must complete the appropriate enrollment form within **60 days** after your death to either enroll in or continue to waive coverage.

What happens if my covered family member is no longer eligible?

You, your dependent, or your beneficiary must report eligibility changes such as death, divorce, or when a dependent is no longer eligible as defined in Washington Administrative Code (WAC) 182-12-260 to us within **60 days** after the change. See "Removing Dependents" on page 13 and "Options for Continuing Coverage" on page 15 for more information.

Can my dependent continue coverage if he or she is no longer eligible under PEBB rules?

It depends on the reason he or she lost eligibility. See "Options for Continuing Coverage" on page 15 for details.

What should I do if my spouse or qualified same-sex domestic partner is also eligible for PEBB coverage as an employee?

PEBB does not allow dual coverage. Enrolled family members may be listed under one account, but not both. This means you could waive the medical coverage on your account and enroll on your spouse's or qualified same-sex domestic partner's account, or enroll under separate accounts. You will need to coordinate with your spouse or qualified same-sex domestic partner to decide who will cover any eligible dependent children.

Selecting a Plan

What medical plans are available?

See "Medical Plans Available by County" on pages 20-22.

What dental plans are available?

See "How the Dental Plans Work" on page 37.

How do the plans differ?

See "How the Medical Plans Work" on page 17 **and "How the Dental Plans Work" on page 37.**

How do I select the best medical and dental plans for my family?

See "Selecting the Best Medical Plan for You and Your Family" on page 19 **and "Dental Benefits Comparison" on page 38.**

Do my covered family members have to enroll in the same plan(s) I choose?

Yes. PEBB rules require all family members to enroll in the same plan.

Preexisting Conditions

There are no preexisting condition restrictions or waiting periods for any PEBB-sponsored medical or dental plan

Blue ink indicates information only for subscribers who have dental coverage.

Cost

How much do the plans cost?

If you are a state or higher-education employee, see the "2007 Monthly Premiums" chart on page 18. If you are employed by a school district, city or county government, or another employer group, contact your payroll, personnel, or benefits office for premiums. In addition to your monthly premiums, you must pay for any deductibles, coinsurance, or copayments under the plan you choose. See the certificate of coverage available from each plan for detailed information.

Premiums Paid With Pretax Dollars

If you are a state agency or higher-education employee, you may pay health plan premiums with pretax dollars. Internal Revenue Service code Section 125 allows us to deduct money from your paycheck before certain payroll taxes and your income tax are calculated. This rule allows for deductions including monthly premiums for your medical coverage and for the state's dependent care program. **If you are not a state or higher-education employee, please check with your payroll, personnel, or benefits office to see if your employer offers this benefit.**

Why should I pay my monthly health care premiums with pretax dollars?

While the difference is not very noticeable, you take home more money, because taxes are calculated after the premium is deducted. By paying for your coverage this way, you reduce your taxable income, which lowers your taxes and saves you money.

Do I need to sign up for a Section 125 deduction?

No. Your health care premiums will be automatically deducted from your earnings before taxes are calculated ***unless you sign the Section 125 waiver form saying you do not want to pay your premiums with pretax earnings.*** The waiver form is available in your agency's personnel, payroll, or benefits office.

Can I change my mind about participating in a Section 125 deduction?

Yes, but only during the annual open enrollment period and when there is a change in your family circumstances, such as:

- Marriage or divorce.
- Establishment or termination of a qualified same-sex domestic partnership.
- Addition of a new child to your coverage.
- Removal from coverage of a child who has reached PEBB's dependent age limit.

Your employer may also remove you from the Section 125 plan—with notice—if it is necessary to prevent excess tax deferral.

When would it benefit me not to have a Section 125 deduction?

If you have your health plan premiums deducted before your taxes are calculated, the following benefits may also be affected:

- **Social Security—**If your base salary is under the $98,400 per year maximum, Section 125 participation will save you money now by reducing your social security taxes. However, if you are nearing retirement age, your lifetime social security benefit would be calculated using the lower salary.
- **Unemployment compensation—** Section 125 also reduces the base salary used to calculate unemployment compensation.

To waive your Section 125 option, complete the waiver form and return it to your agency's personnel, payroll, or benefits office.

Where can I get more information about Section 125?

For advice on your individual situation, you should talk to a qualified financial planner or your local Social Security Office.

Providers

How do I know if my doctor or hospital belongs to a plan?

You must call the plan directly. For medical **or dental** plans, refer to the telephone numbers listed at the front of this booklet. When you call the plan, be sure to mention that you are a PEBB state of Washington enrollee.

You may also search for providers, hospitals, and pharmacies that contract with the medical plans you're interested in at the online Provider Directory at **www.pebb.hca.wa.gov**. If a provider is listed, call the medical plan(s) to confirm his or her participation.

May I change providers after I have joined a plan?

Yes, although rules vary from plan to plan. Call your plan directly for details.

Do all members of my family have to

Questions and Answers

use the same provider?

They can select the same provider, but it's not required. Each dependent may select his or her own provider available through the plan.

If I want the freedom to see any doctor or health care provider without a primary care provider referral, which plan should I enroll in?

The Uniform Medical Plan allows freedom of choice for all approved provider types.

Making Changes

When may I change plans?

See "Changing Your Plans" on page 14.

Who should I contact if I have a change of address?

You must contact your personnel, payroll, or benefits office **within 60 days** after you move. If the health plan you are enrolled in is no longer available to you, see "Changing Your Plans" on page 14 for more information.

May I waive my dependent's coverage during the year?

Yes. You may waive coverage for your dependent at any time during the year. However, if your dependent needs to re-enroll in PEBB coverage, please see "Waiving Medical Coverage" on page 14 for details.

How do I enroll a new spouse or qualified same-sex domestic partner or child?

You must submit a revised *Employee Enrollment/Change* form and the appropriate dependent certification form to your personnel, payroll, or benefits office **within 60 days** of the date your dependent became eligible for PEBB coverage. Otherwise, you must wait until the next open enrollment period to enroll your dependents. See "Adding Dependents" on page 13 for more information.

Coordination of Benefits

How does my PEBB coverage work with my other group medical or dental coverage?

If you are also covered through your spouse's or qualified same-sex domestic partner's employer-provided health coverage, call the medical **and/or dental** plans directly to ask how they will coordinate benefits. Coordinating your plan with your spouse's plan may save you money.

PEBB/HCA Administration

Who determines what PEBB benefits will be?

The Legislature establishes how much money is available to spend on benefits. Then the Public Employees Benefits Board (PEBB)—a division of the Health Care Authority (HCA)—establishes eligibility requirements and approves the benefits plans of all participating insurance companies. The Board meets regularly to review benefit and eligibility issues and plan for the future. Board members are listed on page 6.

Who administers the day-to-day operations of these programs?

The HCA purchases and administers benefits within the amount funded by the Legislature. The HCA contracts with health plans and manages its own self-insured plans—the Uniform Medical Plan **and Uniform Dental Plan**, to provide a choice of quality health care options and responsive customer service to its members.

Who do I call if I have a question about an appeal?

Call your medical **or dental** plan for answers to questions about your plan's appeal process.

If you've already filed an appeal and are not satisfied with the decision, contact your plan about further appeal rights.

If your questions are not answered by your plan within its appeal timelines, you may call PEBB at 1-800-200-1004 for assistance.

Please note

You are not allowed to change plans during the year, even if your doctor, dentist, or health care facility leaves your plan during the plan year.

You will have to wait until the next annual open enrollment period to change your plan.

If you transfer from one agency or school to another during the plan year, you are not permitted to change plans, except in certain circumstances explained in "Changing Your Plans" on page 14.

Blue ink indicates information only for subscribers who have dental coverage.

Eligibility and When Coverage Begins

New Employees

The following employees of state government, higher education, participating K-12 school districts, educational service districts, and employer groups are eligible to apply for PEBB coverage.

Permanent Employees

If you are expected to work at least half-time per month for more than six months, your coverage will begin on the first day of employment. Coverage begins on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.)

Nonpermanent Employees

If you work at least half-time and you are expected to be employed for no more than six months, you are a nonpermanent employee. If your employment continues beyond the initial six-month period, you become eligible for coverage. Your coverage would begin on the first day of the seventh calendar month of employment.

Career Seasonal Employees

If you work at least half-time per month during a designated season, and you have an understanding of continued employment year after year, you are eligible for coverage. Your coverage will begin on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.) If you work a designated season that extends nine or more months, you are eligible for the employer contribution during the break between seasons.

If you work a designated season for less than nine months, you are not eligible for the employer contribution during the break between seasons of employment, but you may continue coverage by paying your own premiums.

Instructional Year Employees

If you work half-time or more on an instructional year (school year) or equivalent nine-month seasonal basis, you are eligible for coverage. Your coverage will begin on the first day of the month following your date of employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.) You are eligible for the employer contribution for coverage during the off-season following each instructional year period of employment.

Part-Time Faculty and Part-Time Academic Employees

If you work at least half-time at one or more state institutions of higher education on a quarter/semester to quarter/semester basis, you become eligible for coverage beginning with the second consecutive quarter/semester. When determining eligibility, spring and fall are considered consecutive quarters/semesters. Your coverage will begin on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. (An exception is made if you begin work on the first working day of the month; in this case, coverage begins that day.)

Part-time academic employees of community and technical colleges who have a reasonable expectation of continued employment are eligible for the employer contribution for benefits during the quarter break immediately following the end of one academic year or equivalent nine-month season.

Appointed and Elected Officials

If you are a legislator or an elected or full-time appointed official of the legislature or executive branch of state government, you are eligible for coverage. If you are a legislator, your coverage will begin on the first day of the month your term begins or the first working day of the month. (An exception is made if the date your term begins is the first working day of the month; in this case, coverage begins that day.)

If you are an elected or full-time appointed official of the legislative or executive branches of state government, your coverage will begin the first day of the month your term begins or the first day of the month you take the oath of office, whichever is earlier. (An exception is made if your term begins or you take your oath of office on the first working day of a month; in this case, coverage begins that day.)

Judges

If you are a Supreme Court Justice or a Court of Appeals or Superior Court judge, you are eligible for coverage. Your coverage will begin on the first day of the month following the date your term begins or the first day of the month you take the oath of office, whichever is earlier. (An exception is made if your term begins or you take the oath of office on the first working day of the month; in this case, coverage begins that day.)

Eligibility and When Coverage Begins

When Coverage Begins for Employees Returning from Leave Without Pay

Employer contributions for PEBB coverage will resume on the first day of the month you return to work and are in pay status for eight or more hours. You will be reimbursed if you have paid your own premiums for any month that you were eligible for a premium contribution by your employer.

Dependents

As a PEBB subscriber, you may enroll the following dependents:

- Your lawful spouse. You must complete a *Declaration of Marriage or Same-Sex Domestic Partnership* form.
- A same-sex domestic partner qualified through the declaration certificate issued by PEBB. You must complete a *Declaration of Marriage or Same-Sex Domestic Partnership* form.
- Your dependent children through age 19. The term "children" includes your biological children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of your qualified same-sex domestic partner, or children specified in a court order or divorce decree.

  Married children who qualify as your dependents under the Internal Revenue Code and extended (legal) dependents approved by PEBB are included.

  For extended dependents to qualify for enrollment, you must submit a completed *Extended Dependent Certification* form. You must also demonstrate legal custody for the child with a court order and the child:

  - Must be living with you (the subscriber) in a parent-child relationship.
  - Must not be a foster child for whom support payments are made to you through the Department of Social and Health Services (DSHS) foster care program.

  Children are eligible beyond age 19 under the following conditions:

  - Dependent children ages 20 through 23 who are registered students and attending classes at an accredited secondary school, college, university, vocational school, or school of nursing. Dependent student coverage continues year-round for students who attend three of the four school quarters or two of three school semesters, and for three months after graduation as long as you are covered at the same time, your dependent has not reached age 24, and he or she meets all other eligibility requirements. You must submit a completed *Student Certification/Change* form when you enroll your student, annually, and whenever requested by the PEBB.
  - Dependent children of any age with disabilities, developmental disabilities, mental illness, or mental retardation who are incapable of self-support are eligible for PEBB coverage if their condition occurred before age 20 or while the dependent was eligible for student coverage under PEBB rules.

    You must provide proof that the disability occurred before age 20 or during the time he or she was eligible for student coverage under PEBB rules. This proof must be provided by submitting a completed *Certification of Dependents With Disabilities* form to PEBB for approval by the health plan. Proof of ongoing eligibility will be requested periodically by PEBB on behalf of the plan.

    You must submit proof before the dependent loses eligibility under PEBB rules (for example, due to age or no longer a student).
  - Your dependents who were previously covered under a K-12 or employer group health plan and who are not otherwise eligible for PEBB coverage may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation of coverage, the PEBB plan must replace a K-12 or employer group health plan with no lapse in coverage.

College students who attend a school outside of their plan's service area may receive network-level benefits through any licensed provider.

UMP PPO enrollees may receive out-of-network benefits from any approved provider type.

Benefits are administered differently from plan to plan. Contact your plan for details.

Blue ink indicates information only for subscribers who have dental coverage.

Adding Dependents

If you add eligible dependents, they will be covered under the same medical **and/or dental** plan(s) you choose. See "Medicare Entitlement" on page 16 for if you or one of your dependents is entitled to Medicare.

You may add family members to your coverage during the year if you have a change in family status. To add an eligible dependent, you must send a completed *Employee Enrollment/Change* form and appropriate dependent certification form(s), if required, within **60 days** of the event. See "Dependents" on page 12 for details on required certification forms.

When you add an eligible dependent to your PEBB coverage due to one of the following situations, his or her coverage will begin as noted:

- **Marriage or establishment of a qualified same-sex domestic partnership—**Coverage begins the first of the month following eligibility.
- **Newborn children—**Coverage begins on the date of birth.
- **Adopted children—**Coverage begins on the date you assume legal obligation for support in anticipation of adoption.
- **Dependent begins school—** Coverage begins the first day of the month of the quarter/semester in which the student registers and begins attending school.
- **Dependents who previously waived PEBB coverage—** Coverage begins the first day of the month after other employer-sponsored coverage ends.

Dependents who previously waived PEBB coverage and then lose other medical coverage must enroll in a PEBB plan within **60 days** of the date their other coverage ends. Dependents must provide proof of continuous, comprehensive, employer-sponsored coverage up to the time their other coverage ends.

When a new dependent is enrolled before the 16th day of the month, you pay the full month's premium; otherwise, the new premium will begin with the next full calendar month.

You may also add eligible dependents during the annual open enrollment period. Open enrollment occurs each fall, and coverage changes begin on January 1 of the following year.

Note: Surviving dependents of emergency services personnel cannot add newly acquired dependents.

Removing Dependents

You must notify PEBB in writing within **60 days** after your spouse, qualified same-sex domestic partner, or child is no longer an eligible dependent under WAC 182-12-260. The following are examples of events that affect dependent eligibility:

- Divorce. Provide a copy of the decree.
- Dissolution of your qualified same-sex domestic partnership.
- Death.
- Your dependent student is no longer enrolled in school.
- Your dependent becomes capable of self-support. Eligibility ends on the last day of the month in which the child became capable of self-support. Children age 20 or older who become capable of self-support cannot regain eligibility for PEBB coverage if they later become incapable of self-support.

Dependents may continue their PEBB enrollment after they are no longer eligible, as long as you notify PEBB of the dependent's ineligibility in writing within the **60-day** period. Options for continuing coverage vary, depending on the reason eligibility was lost. See "Options for Continuing Coverage" on page 15 for more information.

If you misrepresent or fail to notify PEBB of changes that result in your dependent's loss of eligibility (including student status) within **60 days**, your dependent's coverage may be terminated. You must pay the cost of any services received during the time the family member was not eligible for coverage. In addition, PEBB rules limit refunds to three months of adjusted premium.

We may request verification of PEBB eligibility at any time.

Eligibility and When Coverage Begins

Waiving Medical Coverage

Eligible employees may waive PEBB-sponsored medical coverage if they are covered by another health plan. However, **if you waive coverage for yourself, medical coverage will automatically be waived for all dependents.**

If you are a state agency or higher-education employee who is eligible for PEBB benefits, you cannot waive dental coverage for yourself. You may waive dental coverage for family members if they have other continuous comprehensive group dental coverage.

To waive medical coverage, you must submit a completed enrollment form (Section 1 is for the subscriber) and certify that you have other continuous, comprehensive group medical coverage in the Signature section.

If you have other comprehensive group coverage, you should check the coordination of benefits rules for your other coverage and compare the advantages and disadvantages of participating in one or both plans.

Once you or your dependent waives coverage, you may enroll in PEBB coverage:

- During the next open enrollment period. You may re-enroll or add eligible dependents during open enrollment without proof of continuous, comprehensive group coverage.
- Within 60 days after the loss of other medical coverage if you provide proof that you and your dependent(s) had other continuous coverage in a comprehensive group medical plan.
- If you have a qualifying change in family status, such as:
  - Marriage.
  - Establishment of a qualified same-sex domestic partnership.
  - Birth.
  - Adoption or placement for adoption.

Re-enrollment must be requested within **60 days** of the change in family status. For example, if you have a birth, you may also enroll your spouse who previously waived medical coverage as long as you request the enrollment within **60 days** of the marriage or within **60 days** of the child's birth date. However, you may not change medical plans.

Note: K-12 employees may ***not*** be permitted by their school district to re-enroll until the next open enrollment or renegotiation period.

Changing Your Plans

Your coverage is for an entire year (January 1 through December 31) unless you waive coverage. However, you may change plans during the year in the following situations:

- If you move, you may change your plan enrollment within **60 days** of your move under these conditions:
  - If your plan is no longer available, you may enroll in any plan available in your new location. If you do not select a new plan, we will enroll you in the Uniform Medical Plan (UMP).
  - If a plan that was not available to you is offered in your new location, you may enroll in that plan.

  All such plan enrollment changes usually begin the first day of the month after your move.
- If a court order requires you to provide medical coverage for an eligible spouse, qualified same-sex domestic partner, or child, you may change medical plans and add the family member. The change is effective the first day of the month after PEBB receives a completed application with all necessary supporting documentation.
- If you are a seasonal employee whose off-season occurs during open enrollment, you may change plans within **31 days** of returning to work.
- During annual open enrollment, usually held in the fall, with coverage changes beginning the following January 1.
- When you apply for retiree coverage (the change is on the same day retiree coverage takes effect).

An enrollee also may change health plans in some other exceptional cases described in WAC 182-08-198.

Know Your Benefits

You are responsible for knowing your benefits and your plan's rules for using providers, preauthorizations, and medical review to avoid penalty or loss of benefits. You can find these rules in your plan's certificate of coverage.

Some benefits described in this guide are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

Blue ink indicates information only for subscribers who have dental coverage.

When Coverage Ends

Your PEBB coverage ends on the last day of the month you are employed or your dependent loses eligibility under PEBB rules.

For information on continuation coverage options, contact your personnel, payroll, or benefits office. You may also contact PEBB Benefit Services toll-free at 1-800-200-1004.

If you or a covered dependent is confined in a hospital or other medical facility when your coverage ends, contact PEBB within **31 days** to determine whether you or your dependent qualifies for an extended benefit.

Options for Continuing Coverage

You and/or your dependents may continue your PEBB coverage by self-paying your premiums after your eligibility ends. Options for continuing coverage vary, based on the reason you lost eligibility. See your plan's certificate of coverage for more information.

You must apply to continue your coverage within **60 days** after the event that caused you to lose eligibility, or you will lose all rights to continue PEBB coverage. Here are your continuing coverage options:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 .
- PEBB Extension of Coverage.
- Leave Without Pay (LWOP) coverage.
- PEBB-sponsored retiree coverage.

The first three options temporarily extend PEBB medical coverage in certain circumstances when you would otherwise lose group medical **and dental** coverage. Eligibility for COBRA continuation coverage is defined in federal law and the plan program is administered according to federal rules.

PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

PEBB-sponsored retiree coverage is available only to retirees or surviving dependents who meet the eligibility criteria outlined in PEBB rules. (See Washington Administrative Code [WAC] 182-12-171, 182-12-250, or 182-12-265.)

All four continuing coverage options are administered by the Health Care Authority (HCA). Refer to your *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* for specific details or call PEBB Customer Service at 1-800-200-1004.

If you enroll in a flexible spending account (FSA) in 2007 and later terminate employment, retire, or go on unpaid leave, your eligibility for your FSA may change. You may elect continuation coverage by contacting ASI, the PEBB program's FSA administrator, at 1-800-659-3035 or by sending an e-mail to **asi@asiflex.com.**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

COBRA requires most employers sponsoring group plans to offer employees and their families the opportunity for a temporary extension of health coverage at group rates when coverage ends because of certain "qualifying events." If you have the right to continue group coverage, you must enroll within 60 days of the event that led to your loss of PEBB coverage and pay your own premiums. COBRA rates exceed other self-pay rates by 2 percent. See your plan's certificate of coverage for details.

Medicare Entitlement

Medicare Parts A and B

Employees and their spouses or qualified same-sex domestic partners age 65 and older who choose to enroll in both Part A and Part B of Medicare have two coverage options available:

- You may **continue your employer-sponsored medical plan.**

  The PEBB medical plan will be your primary insurer and Medicare coverage will be secondary. The state offers more comprehensive medical coverage than Medicare, so **it is to your advantage to choose the PEBB-sponsored plan as your primary coverage.**

- You may **cancel your employer-sponsored medical plan** and select Medicare as your primary insurer.

  If you choose this option, you will not be allowed to continue enrollment in your PEBB medical plan; however, you will remain enrolled in PEBB **dental**, life, and long-term disability coverage.

  You will not be allowed to re-enroll in PEBB medical coverage offered to active employees, and your family members will lose their PEBB coverage.

  You may enroll in PEBB coverage at retirement. **If you want Medicare as your primary coverage, you must notify PEBB in writing.**

Medicare Part B

In most situations, you and your spouse or qualified same-sex domestic partner can defer Medicare Part B enrollment, without penalty, up to the date you end your employment or retire. When you retire, Medicare will become the primary insurer, and the PEBB-sponsored medical plan becomes secondary.

Medicare Part D

This is a voluntary program that began in 2006. It is available to Medicare beneficiaries enrolled in Medicare Part A and/or Part B.

Medicare Part D contracts with prescription-drug plans to provide at least a standard level of coverage set by Medicare. Some plans offer more coverage for a higher monthly premium.

Prescription-drug coverage in PEBB-sponsored medical plans is as good or better than the standard Medicare Part D coverage. This means you would not pay a late enrollment penalty to enroll in Part D at some future date.

If you are enrolled in a PEBB medical plan and Medicare Part A, you are eligible to enroll in Medicare Part D. If you choose Part D, you may keep your PEBB health coverage. However, your PEBB medical plan may not coordinate prescription-drug benefits with your Medicare Part D prescription-drug plan.

Blue ink indicates information only for subscribers who have dental coverage.

How the Medical Plans Work

The medical plans may differ in terms of their cost, type of providers and facilities, referral practices, and guidelines. While the plans have a basic level of benefits, some plans offer additional benefits or lower copays at no additional cost. The value plans offer lower premiums if you are willing to pay more when you use health care services.

Please note: Services provided by plan-designated *alternative care providers* will be covered if the service they provide is within the scope of their license, covered by the PEBB benefit plan, and approved by your medical plan. Please check with the medical plans for information about coverage for a specific service.

There are three types of medical plans–here's how they work.

1 Classic managed-care plans:

In this type of plan, you usually must see providers in your plan's network. Most services you receive are provided through, or referred by, a primary care provider (PCP) of your choice within the plan's network. Some plans allow self-referral for some types of specialty care. Nonemergency services outside the service area, or services not provided or authorized by your PCP, are not covered.

Most services require a $10 copayment at the time of service, and there is no annual deductible. The annual out-of-pocket maximum is $750 per person or $1,500 per family.

Emergency care is covered worldwide.

2 Value managed-care plans:

Like the classic managed-care plans, you must see providers in your plan's network and receive most services (or a referral) from your PCP within the plan's network.

Value plans require you to pay an annual deductible, and have a higher copay for office visits compared to classic plans. Value plans also have an annual $1,500 per person or $3,000 per family out-of-pocket maximum.

Emergency care is covered worldwide.

3 Preferred provider organization (PPO):

The Uniform Medical Plan (UMP) is a freedom-of-choice plan that allows you to self-refer to any approved provider type in most cases, but provides a higher level of coverage if the provider contracts with UMP's extensive provider network. Most services are subject to an annual deductible, and there is an annual $1,500 per person or $3,000 per family out-of-pocket maximum.

UMP provides worldwide coverage for routine and emergency care.

PEBB does not allow dual coverage.

If you and your spouse or qualified same-sex domestic partner are both eligible for PEBB coverage, you need to decide which of you will cover any eligible children on your medical and/or dental plan. An enrolled family member may be listed on one account, but not both. This means you could waive the medical coverage on your account and enroll on your spouse's or same-sex domestic partner's account.

2007 Monthly Premiums for State Agency and Higher-Education Employees

Please note: ***School district employees and those who work for a city, county, port, water district, hospital, etc. need to contact their personnel, payroll, or benefits office to get their monthly premium amounts.***

PEBB Medical Plans	Employee	Employee & Spouse*	Employee & Child(ren)	Employee, Spouse* & Child(ren)
Community Health Plan Classic	$101	$212	$177	$288
Group Health Classic	57	124	100	167
Group Health Value	13	36	23	46
Kaiser Permanente Classic	70	149	122	202
Kaiser Permanente Value	31	72	54	95
Regence Classic	139	287	242	391
Uniform Medical Plan	24	57	41	75
*or qualified same-sex domestic partner				

Blue ink indicates information only for subscribers who have dental coverage.

Selecting the Best Medical Plan for You and Your Family

All medical plans, with the exception of Medicare Supplement Plan E and Plan J, offer the same basic benefits, although benefit enhancements, limitations, premiums, annual deductibles, copays, coinsurance, and out-of-pocket maximums may vary. For example, value plans have lower monthly premiums, but they also have annual deductibles and higher copays for office visits. Only you can decide which plan makes the most sense for you and your family.

Keep in mind: If you cover eligible dependents, they must be covered under the same medical plan you choose.

As you review the plans, here are some things to consider:

- **Geography.** In most cases, you must live in the plan's service area to join the plan. See "Medical Plans Available by County" on pages 20-22. Be sure to contact the plan(s) you're interested in to ask about provider availability in your county.
- **Cost.** Premiums vary by plan. Keep in mind, higher cost doesn't necessarily mean higher quality of care or higher benefits; each plan has the same basic level of benefits. The Public Employees Benefits Board sets the premiums for state agency and higher-education employees, based on funding from the Legislature. **If you are employed by a school district, city, county, port, water district, hospital, or other employer group, contact your payroll, personnel, or benefits office to get your monthly premiums.**
- **Unique medical needs.** If you or a dependent needs specific medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. **Please note:** Each plan has a different formulary or list of approved prescription drugs the plan will cover.
- **Coinsurance vs. copays.** PEBB classic and value managed-care plans require you to pay a fixed portion (called a "copay" or "copayment") and/or a coinsurance (percentage of an allowed fee) when you receive network care. UMP requires you to pay a coinsurance.
- **Deductible.** Value managed-care plans and UMP require you to pay an annual deductible before the plan pays for covered services. The UMP also has a separate annual deductible for prescription drugs. Preventive care and certain other benefits are exempt from most value plans' annual deductibles and from the UMP's annual medical deductible.
- **Out-of-pocket maximum.** This is the maximum amount you pay in one calendar year. Once you have paid this amount, most plans pay 100 percent of allowed charges for a majority of covered services for the remainder of the calendar year. The out-of-pocket maximum varies by plan. Deductibles are not applied toward your out-of- pocket maximum.
- **Referral procedures.** Some plans allow you to self-refer to any network provider; others require you to have a referral from your primary care provider. All plans allow self-referral to a participating provider for women's health care services.
- **Your provider.** If you have a long-term relationship with your doctor or health care provider, you must verify whether he or she is a primary care provider in the plan's network before you join by calling the plan directly.
- **Paperwork.** In general, PEBB plans don't require you to file claims. However, UMP members may need to file a claim if they receive services from a provider outside of UMP's network.
- **Coordination with your other benefits.** See "Coordination of Benefits" information on page 10.

Questions? Contact the medical plans directly (phone numbers are listed on the inside front cover).

Want more help making a medical plan choice?

Go to the PEBB's Web site at **www.pebb.hca.wa.gov** to use the Provider Directory and visit the medical plans' Web sites.

Medical Plans Available by County

Washington

Adams
- Community Health Plan Classic
- Uniform Medical Plan

Asotin
- Uniform Medical Plan

Benton
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Chelan
- Community Health Plan Classic
- Uniform Medical Plan

Clallam
- Regence Classic
- Uniform Medical Plan

Clark
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Regence Classic
- Uniform Medical Plan

Columbia
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Cowlitz
- Community Health Plan Classic
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Regence Classic
- Uniform Medical Plan

Douglas
- Community Health Plan Classic
- Uniform Medical Plan

Ferry
- Community Health Plan Classic
- Uniform Medical Plan

Franklin
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Garfield
- Uniform Medical Plan

Grant
- Community Health Plan Classic
- Uniform Medical Plan

Grays Harbor
- Community Health Plan Classic
- Group Health Classic (ZIP Codes 98541, 98557, 98559, and 98568)
- Group Health Value (ZIP Codes 98541, 98557, 98559, and 98568)
- Regence Classic
- Uniform Medical Plan

Island
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Jefferson
- Regence Classic
- Uniform Medical Plan

King
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Kitsap
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Kittitas
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Klickitat
- Community Health Plan Classic
- Uniform Medical Plan

Lewis
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Kaiser Permanente Classic (ZIP Codes 98591, 98593, and 98596)
- Kaiser Permanente Value (ZIP Codes 98591, 98593, and 98596)
- Regence Classic
- Uniform Medical Plan

Lincoln
- Community Health Plan Classic
- Group Health Classic (ZIP Codes 99008, 99029, 99032, and 99122)
- Group Health Value (ZIP Codes 99008, 99029, 99032, and 99122)
- Uniform Medical Plan

Mason
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

In most cases, you must live in the plan's service area to join the plan.
Be sure to call the plan(s) you're interested in to ask about provider availability in your county.

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Okanogan
- Community Health Plan Classic
- Uniform Medical Plan

Pacific
- Community Health Plan Classic (ZIP Codes 98624, 98631, 98637, 98638, 98640, 98641, and 98644)
- Regence Classic
- Uniform Medical Plan

Pend Oreille
- Community Health Plan Classic
- Group Health Classic (ZIP Code 99009)
- Group Health Value (Zip Code 99009)
- Uniform Medical Plan

Pierce
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

San Juan
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Skagit
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Skamania
- Community Health Plan Classic
- Kaiser Permanente Classic (ZIP Codes 98639 and 98648)
- Kaiser Permanente Value (ZIP Codes 98639 and 98648)
- Uniform Medical Plan

Snohomish
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Spokane
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Stevens
- Community Health Plan Classic
- Group Health Classic (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Group Health Value (ZIP Codes 99006, 99013, 99026, 99034, 99040, 99110, 99148, and 99173)
- Uniform Medical Plan

Thurston
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Wahkiakum
- Kaiser Permanente Classic (ZIP Codes 98612 and 98647)
- Kaiser Permanente Value (ZIP Codes 98612 and 98647)
- Uniform Medical Plan

Walla Walla
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Whatcom
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

Whitman
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Yakima
- Community Health Plan Classic
- Group Health Classic
- Group Health Value
- Regence Classic
- Uniform Medical Plan

The Uniform Medical Plan is available worldwide.

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In most cases, you must live in the plan's service area to join the plan.
Be sure to call the plan(s) you're interested in to ask about provider availability in your county.

Medical Plans Available by County

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Oregon

Benton
- Kaiser Permanente Classic (ZIP Codes 97330, 97331, 97333, 97339, and 97370)
- Kaiser Permanente Value (ZIP Codes 97330, 97331, 97333, 97339, and 97370)
- Uniform Medical Plan

Clackamas
- Kaiser Permanente Classic (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97222, 97267, and 97268)
- Kaiser Permanente Value (ZIP Codes 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97222, 97267, and 97268)
- Uniform Medical Plan

Columbia
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Hood River
- Kaiser Permanente Classic (ZIP Code 97014)
- Kaiser Permanente Value (ZIP Code 97014)
- Uniform Medical Plan

Lane
- Uniform Medical Plan

Linn
- Kaiser Permanente Classic (ZIP Codes 97321–22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Kaiser Permanente Value (ZIP Codes 97321–22, 97335, 97355, 97358, 97360, 97374, and 97389)
- Uniform Medical Plan

Marion
- Kaiser Permanente Classic (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- Kaiser Permanente Value (ZIP Codes 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-14, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383-85, and 97392)
- Uniform Medical Plan

Multnomah
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Polk
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Umatilla
- Group Health Classic (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Group Health Value (ZIP Codes 97810, 97813, 97835, 97862, 97882, and 97886)
- Uniform Medical Plan

Washington
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Yamhill
- Kaiser Permanente Classic
- Kaiser Permanente Value
- Uniform Medical Plan

Idaho

Kootenai
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Latah
- Group Health Classic
- Group Health Value
- Uniform Medical Plan

Nez Perce
- Uniform Medical Plan

The Uniform Medical Plan is available worldwide.

In most cases, you must live in the plan's service area to join the plan. Be sure to call the plan(s) you're interested in to ask about provider availability in your county.

Blue ink indicates information only for subscribers who have dental coverage.

2007 Medical Benefits Cost Comparison

The following table briefly compares the costs of network benefits for the Uniform Medical Plan (UMP) and in-network benefits for PEBB classic and value managed-care plans. Benefit costs and plan payments are per calendar year, unless otherwise noted. **Call the plans directly for more information on specific benefits or exclusions.**

Benefits for:	**CLASSIC MANAGED-CARE PLANS:** ***Community Health Plan Classic*** ***Group Health Classic*** ***Kaiser Permanente Classic*** ***Regence Classic***	**VALUE MANAGED-CARE PLANS:** ***Group Health Value*** ***Kaiser Permanente Value***	**PREFERRED PROVIDER ORGANIZATION:** ***Uniform Medical Plan***
Lifetime maximum	$2 million	$2 million	$2 million
Benefits for:			
Annual deductible	None	Enrollee pays $100 per person/ $300 per family Annual deductible does not apply to preventive care visits.	Medical services: Enrollee pays $200 per person/$600 per family (three or more people) Annual deductible does not apply to preventive care visits Brand-name prescription drug deductible: Applies to Tier 2 and Tier 3 drugs only; enrollee pays $100 per person/$300 per family (three or more people)
Annual out-of-pocket maximum	Enrollee pays $750 per person/ $1,500 per family for network benefits Expenses as defined in the certificate of coverage ***do not count*** toward the out-of-pocket maximum	Enrollee pays $1,500 per person/$3,000 per family for network benefits Expenses as defined in the certificate of coverage ***do not count*** toward the out-of-pocket maximum	Enrollee pays $1,500 per person/$3,000 per family (prescription drugs, non-network provider services, deductibles, and other expenses as defined in the certificate of coverage ***do not count*** toward the out-of-pocket maximum)

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The health plan comparisons in this document are based on information believed to be accurate and current, but be sure to confirm information with the plans before making decisions.

Blue ink indicates information only for subscribers who have dental coverage.

2007 Medical Benefits Cost Comparison

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Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Office, clinic, and hospital visits	$10 copay per office/clinic visit; hospital visits covered in full	***Group Health*:** $15 copay per office/clinic visit; ***Kaiser Permanente:*** $20 copay per office/clinic visit	Enrollee pays 10% of allowed charges
Ambulance	**Air:** $100 copay per trip **Exception:** ***Kaiser Permanente*,** $75 copay per trip **Ground:** $75 copay per trip	**Air:** $100 copay per trip **Exception:** ***Kaiser Permanente*,** 10% coinsurance **Ground:** $75 copay per trip **Exception:** ***Kaiser Permanente*,** 10% coinsurance	**Air:** Enrollee pays 20% of allowed charges, plus the difference between allowed and billed charges **Ground:** Enrollee pays 20% of allowed charges, plus the difference between allowed and billed charges
Chemical dependency services	**Inpatient:** Enrollee pays inpatient hospital copay; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment **Outpatient:** $10 copay; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment for all plans	**Inpatient:** Enrollee pays inpatient hospital copay for ***Group Health*** and coinsurance for ***Kaiser Permanente***; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment **Outpatient:** ***Group Health:*** $15 copay; ***Kaiser Permanente:*** $20 copay; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment for all plans	**Inpatient:** Enrollee pays inpatient hospital copay; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment **Outpatient:** Enrollee pays 10% of allowed charges; maximum plan payment of $13,500 per 24 consecutive calendar month period for any combination of inpatient/outpatient treatment

Blue ink indicates information only for subscribers who have dental coverage.

Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Diabetic education	$10 copay per visit	***Group Health:*** $15 copay per visit; ***Kaiser Permanente:*** $20 copay per visit	Enrollee pays 10% of allowed charges
Diagnostic testing	Covered in full	***Group Health:*** Covered in full; ***Kaiser Permanente:*** 10% coinsurance	Enrollee pays 10% of allowed charges
Durable medical equipment, supplies, and prosthesis	Enrollee pays 20% coinsurance	Enrollee pays 20% coinsurance	Enrollee pays 10% of allowed charges; preauthorization required for equipment rentals beyond three months and rentals or purchases of more than $1,000
Emergency room services	$75 copay per visit; emergency room copay waived if admitted directly to hospital	***Group Health:*** $75 copay per visit; ***Kaiser Permanente:*** $100 copay Emergency room copay waived for both plans if admitted directly to hospital	$75 copay per visit, then enrollee pays 10% of allowed charges; copay waived if admitted directly to hospital
Hearing (examination and hardware)	**Examination:** $10 copay **Hardware:** $300 maximum plan payment every 36 consecutive months for hearing aid and rental/repair when authorized	**Examination:** ***Group Health:*** $15 copay; ***Kaiser Permanente:*** $20 copay **Hardware:** $300 maximum plan payment every 36 consecutive months for hearing aid and rental/repair when authorized	Enrollee pays 10% of allowed charges; maximum plan payment of $400 every three calendar years for exams, hearing aid, and rental/repair combined

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The health plan comparisons in this document are based on information believed to be accurate and current, but be sure to confirm information with the plans before making decisions.

2007 Medical Benefits Cost Comparison

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Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Home health care	Covered in full	***Group Health:*** Covered in full; ***Kaiser Permanente:*** 10% coinsurance	Enrollee pays 10% of allowed charges
Hospice care (including respite care)	Covered in full for terminally ill enrollees up to six months	Covered in full for terminally ill enrollees up to six months	If preapproved by plan, covered in full; $5,000 lifetime maximum plan payment for respite care
Hospital services	**Inpatient services:** $200 copay per day to $600 maximum copay per person per calendar year **Outpatient:** $100 copay for facility fees per surgery or procedure; surgeon, anesthesiologist, etc., covered in full	**Inpatient services:** ***Group Health:*** $200 copay per day to $600 maximum copay per person per calendar year; ***Kaiser Permanente*:** 10% coinsurance **Outpatient:** ***Group Health:*** $150 copay for facility fees per surgery or procedure; surgeon, anesthesiologist, etc., covered in full; ***Kaiser Permanente*:** 10% coinsurance	**Inpatient services:** $200 copay per day to $600 maximum copay per person per calendar year plus 10% of allowed charges for professional services **Outpatient:** Enrollee pays 10% of allowed charges
Massage therapy	Included in physical, occupational, and speech therapy benefit	Included in physical, occupational, and speech therapy benefit	Enrollee pays 10% of allowed charges, up to 16 visits per calendar year

Blue ink indicates information only for subscribers who have dental coverage.

Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Mental health care	**Inpatient services:** $200 copay per day to $600 maximum copay per person per calendar year Plan payment limit up to 10 days per year (For more information, contact the plans.) **Outpatient:** $10 copay per office/clinic visit, up to 20 visits per year	**Inpatient:** Enrollee pays inpatient hospital copay for ***Group Health*** and coinsurance for ***Kaiser Permanente;*** plan payment limit up to 10 days per year (For more information, contact the plans.) **Outpatient:** ***Group Health,*** $15 copay; ***Kaiser Permanente,*** $20 copay per office/clinic visit, up to 20 visits per year	**Inpatient:** Enrollee pays inpatient hospital copay; plan payment limit up to 10 days per year **Outpatient:** Enrollee pays 10% of allowed charges per office/clinic visit, up to 20 visits per year
Neurodevel-opmental therapies	**Inpatient age 6 and under:** Enrollee pays inpatient hospital copay to 60 days per year **Outpatient age 6 and under:** $10 copay to 60 visits per year for all therapies combined	**Inpatient age 6 and under:** Enrollee pays inpatient hospital copay to 60 days per year **Outpatient age 6 and under:** ***Group Health,*** $15 copay; ***Kaiser Permanente,*** $20 copay to 60 visits per year for all therapies combined	**Inpatient age 6 and under:** Enrollee pays inpatient hospital copay to 60 days per year **Outpatient age 6 and under:** Enrollee pays 10% of allowed charges to 60 visits per year for all therapies combined
Obstetric and well-newborn care	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Covered in full	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Covered in full	**Inpatient:** Enrollee pays inpatient hospital copay for mother only **Professional services:** Enrollee pays 10% of allowed charges

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2007 Medical Benefits Cost Comparison

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Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Organ transplants	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Covered in full; preauthorization required Bone marrow donor searches covered in full, up to 15 searches per person per transplant	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Covered in full; preauthorization required Bone marrow donor searches covered in full, up to 15 searches per person per transplant	**Facility:** Enrollee pays inpatient hospital copay; preauthorization required **Professional services:** Enrollee pays 10% of allowed charges; preauthorization required Enrollee pays 10% of allowed charges for bone marrow, stem cell, and umbilical cord donor searches, up to 15 searches per person per transplant
Physical, occupational, and speech therapy	**Inpatient:** Includes massage therapy Enrollee pays inpatient hospital copay to 60 days per year **Outpatient:** $10 copay to 60 visits per year for all therapies combined	**Inpatient:** Includes massage therapy Enrollee pays inpatient hospital copay to 60 days per year **Outpatient:** ***Group Health,*** $15 copay; ***Kaiser Permanente,*** $20 copay to 60 visits per year for all therapies combined	Does not include massage therapy (See massage therapy benefit.) **Inpatient:** Enrollee pays inpatient hospital copay to 60 days per calendar year; preauthorization required **Outpatient:** Enrollee pays 10% of allowed charges, up to 60 visits per calendar year for all therapies combined

The health plan comparisons in this document are based on information believed to be accurate and current, but be sure to confirm information with the plans before making decisions.

Blue ink indicates information only for subscribers who have dental coverage.

Benefits for:	**CLASSIC MANAGED-CARE PLANS:** ***Community Health Plan Classic*** ***Group Health Classic*** ***Kaiser Permanente Classic*** ***Regence Classic***	**VALUE MANAGED-CARE PLANS:** ***Group Health Value*** ***Kaiser Permanente Value***	**PREFERRED PROVIDER ORGANIZATION:** ***Uniform Medical Plan***
Prescription drugs, insulin, and disposable diabetic supplies	***Community Health Plan Classic and Regence Classic*** **Retail** (up to a one-month supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name, $25 copay; non-formulary, $40 copay **Mail order** (up to 90-day supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name, $50 copay; non-formulary, $80 copay ***Group Health Classic*** **Retail** (up to a one-month supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order** (up to 90-day supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $40 copay ***Kaiser Permanente Classic*** **Retail:** (up to a one-month supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $25 copays **Mail order:** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $50 copay	***Group Health Value*** **Retail** (up to a one-month supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order** (up to 90-day supply)**:** Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $60 copay ***Kaiser Permanente Value*** **Retail:** (up to a one-month supply): Formulary generic, all insulin, and all disposable diabetic supplies, $10 copay; formulary brand-name drugs, $30 copay **Mail order:** (up to 90-day supply): Formulary generic, all insulin, and all disposable diabetic supplies, $20 copay; formulary brand-name drugs, $60 copay	Up to a 90-day supply (Tier 2 and Tier 3 drugs subject to brand-name prescription drug deductible) **Retail:** Tier 1 (generic, all insulin, all disposable diabetic supplies, and preferred specialty drugs), 10% enrollee coinsurance; Tier 2 (preferred brand), 30% enrollee coinsurance; Tier 3* (nonpreferred brand, nonpreferred specialty drugs, and compounded prescriptions), 50% enrollee coinsurance *Note: Tier 1 and 2 drugs purchased through a network retail pharmacy have a maximum enrollee cost share of $75 (up to a 30-day supply), $150 (31- to 60-day supply), and $225 (61- to 90-day supply)* **Mail order:** Tier 1, $10 copay; Tier 2, $50 copay; Tier 3*, $100 copay ***Multi-source Tier 3 drugs are subject to an ancillary charge—the enrollee pays the difference between the Tier 3 drug and the generic equivalent, in addition to the usual copay or coinsurance*** *(continued on next page)*

2007 Medical Benefits Cost Comparison

(continued from previous page)

Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Preventive care	Covered in full, subject to plan schedule **Exception**: ***Regence Classic,*** covered in full as recommended by PCP	Covered in full, subject to plan schedule	Covered in full, subject to plan schedule (not subject to UMP medical deductible) Only services listed in the certificate of coverage are covered as preventive care
Radiation and chemotherapy services	Covered in full	Covered in full	Enrollee pays 10% of allowed charges
Skilled nursing facility care	Enrollee pays inpatient hospital copay; covered up to 150 days per year, except if it substitutes for hospitalization	Enrollee pays inpatient hospital copay or coinsurance; covered up to 150 days per year, except if it substitutes for hospitalization	Enrollee pays inpatient hospital copay; covered up to 150 days per calendar year, except if it substitutes for hospitalization **Medicare retirees**: The first 100 days covered by Medicare count toward your 150-day limit under UMP.
Spinal manipulations	Enrollee pays 50% coinsurance; maximum plan payment of $250 per year **Exception: *Regence Classic*** pays 100% with $10 copay per visit **when enrollee is referred by primary care provider**	Enrollee pays 50% coinsurance; maximum plan payment of $250 per year	Enrollee pays 10% of allowed charges to 10 visits per year

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Benefits for:	CLASSIC MANAGED-CARE PLANS: *Community Health Plan Classic* *Group Health Classic* *Kaiser Permanente Classic* *Regence Classic*	VALUE MANAGED-CARE PLANS: *Group Health Value* *Kaiser Permanente Value*	PREFERRED PROVIDER ORGANIZATION: *Uniform Medical Plan*
Temporo-mandibular joint (TMJ) disorder	Enrollee pays 50% coinsurance for inpatient and outpatient treatment, maximum plan payment of $1,000 per year; orthognathic surgery not covered	Enrollee pays 50% coinsurance for inpatient and outpatient treatment, maximum plan payment of $1,000 per year; orthognathic surgery not covered	Surgical treatment covered same as any other condition; enrollee pays 10% of allowed charges when preauthorized; orthognathic surgery not covered. ***Non-surgical treatment for TMJ is not covered.***
Vision	**Examination:** $10 copay; one annual eye exam **Hardware**: $150 maximum plan payment once every two calendar years for frames, lenses, contacts, and fitting fees combined	**Examination:** ***Group Health,*** $15 copay; ***Kaiser Permanente,*** $20 copay; one annual eye exam **Hardware**: $150 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined	**Examination:** Enrollee pays 10% of allowed charges; one annual eye exam (not subject to UMP medical/surgical deductible) **Hardware**: $150 maximum plan payment every two calendar years for frames, lenses, contacts, and fitting fees combined (not subject to UMP medical/surgical deductible)
Well-baby care	Covered in full; subject to plan schedule	Covered in full; subject to plan schedule	Covered in full, subject to plan schedule (not subject to UMP medical deductible). Only services listed are covered as preventive.

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General Medical Exclusions

Expenses Not Covered, Exclusions, and Limitations

What UMP Doesn't Cover:

UMP PPO covers only the services and conditions specifically identified in the *Certificate of Coverage* (COC). Unless a service or condition fits into one of the specific benefit definitions, it is not covered. If you have questions, call Customer Service at 1-800-762-6004.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list.

1. Acupuncture, except as described under "Acupuncture" in the COC.
2. Air ambulance, if ground ambulance would serve the same purpose, or transportation by "cabulance" or other nonemergency service.
3. Circumcision, unless determined medically necessary for a medical condition.
4. Complications directly arising from services that are not covered.
5. Conditions caused by or arising from acts of war.
6. Cosmetic services or supplies, including drugs, pharmaceuticals, removal of excess tissue and similar procedures. However, UMP does cover:
   - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
   - Reconstructive surgery of a congenital anomaly in a covered dependent child.
7. Court-ordered care, unless determined by UMP to be medically necessary and otherwise covered.
8. Custodial care; see definition in the COC.
9. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed in the COC
10. Dietary or food supplements, including:
    - Herbal supplements, dietary supplements, medicinal foods, and homeopathic drugs.
    - Infant or adult dietary formulas, except for treatment of congenital metabolic disorders detected by newborn screening such as phenylketonuria (PKU) when specialized formulas have been established as effective for treatment.
    - Minerals.
    - Prescription or over-the-counter vitamins (except prenatal vitamins during pregnancy).
11. Dietary programs designed for weight control or weight loss.
12. Drugs or medicines not covered by UMP are described in the "How the UMP PPO Pharmacy Benefit Works" section of the COC.
13. Educational programs, except those listed in the COC under "Diabetes Education," "Educational Programs," and "Tobacco Cessation Program.
14. Electron Beam Tomography (EBT), self-referred or prescribed by a provider.
15. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems.
    - Arch supports.
    - Convenience items and options.
    - Exercise equipment.
    - Sanitary supplies.
16. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
17. Experimental or investigational services, supplies, or drugs, except for clinical trials consistent with Medicare coverage criteria.
18. Extracorporeal Shockwave Therapy; low-energy shock waves focused on a source of pain (soft tissue).
19. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
20. Foot care treatment for complaints such as corns and calluses, or fallen arches; and supplies for correction or treatment of such complaints, for example corrective shoes, orthotics, or related prescriptions. However, see "Durable Medical Equipment, Supplies, and Prostheses" in the COC for coverage related to diabetes.

Blue ink indicates information only for subscribers who have dental coverage.

21. Genetic testing or counseling for family planning, or any other genetic testing or counseling that is not preauthorized. See "Genetic Testing" in the COC for more information on what's covered.

22. Home health care except as provided in the COC. For example, the following are not covered:
    - Any services or supplies not included in the home health care treatment plan or not specifically mentioned in the COC under "Home Health Care."
    - Unless preauthorized:
        - Daily visits.
        - Visits exceeding two hours per day.
        - Visits continuing for more than three weeks.
        - 24-hour or full-time care in the home.
    - Dietary assistance.
    - Expenses for normal necessities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services.
    - Custodial care.
    - Nonclinical social services.
    - Psychiatric care.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services that are not medically necessary.

23. Hospice care except as provided in the COC. For example, the following are not covered:
    - Any services or supplies not included in the hospice care plan, not specifically mentioned under "Hospice Care" in the COC, or provided in excess of the specified limits.
    - Expenses for normal necessities of living such as food, clothing, household supplies, Meals on Wheels, or similar services.
    - Homemaker, chore worker, or housekeeping services (except as provided by home health aides as part of the hospice program).
    - Legal or financial counseling.
    - Separate charges for records, reports, or transportation.
    - Services by family members or volunteer workers.
    - Services provided while the enrollee is receiving home health care benefits.
    - Services to other than the terminally ill enrollee including bereavement, pastoral, or spiritual counseling.

24. Hospital inpatient charges such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Beds "reserved" while the patient is being treated in a special-care unit or is on leave from the hospital.
    - High-cost services and devices that do not meet the medical necessity criteria of "the level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention." Examples include metal-on-metal or ceramic hip prostheses. See additional information under "Hospital Inpatient Services" in the COC.
    - Personal items (television, special diets not medically necessary to treat the covered condition, or convenience items).
    - Private room charges, unless medically necessary and preauthorized by UMP.

25. Immunizations, except as described under "Preventive Care" in the COC. Immunizations for the purpose of travel or employment, or required because of where you reside, or any others not listed, are not covered.

26. Infertility or sterility testing or treatment, including drugs, pharmaceuticals, artificial insemination, and any other type of testing or treatment.

27. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.

28. Learning disabilities treatment after diagnosis, except as described in the COC under "Neurodevelopmental Therapy," or when treatment is part of a mental health disorder and covered under the "Mental Health Treatment" benefit.

29. Maintenance therapy (see definition in the COC).

30. Manipulations of the spine or extremities, except as described under "Spinal and Extremity Manipulations" in the COC.

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General Medical Exclusions

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31. Massage therapy, unless services meet the criteria in "Massage Therapy" in the COC. Also, services from massage therapists who are not UMP network providers, and services not preauthorized that exceed one hour per session, are not covered.
32. Medicare-covered services or supplies delivered under a "private contract" with a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see "Provider Options for Medicare Retirees" in the COC for more information).
33. Mental health – UMP does not cover marital, family, or other counseling or training services, except when provided to treat neuropsychiatric, mental, or personality disorders (coverage is described in the COC). Services from non-PhD psychologists are covered only when they are employed by and deliver services within a licensed community mental health agency and that agency bills for the services. Wilderness training programs are not covered.
34. Missed appointments.
35. Non-approved provider types—Services delivered by types of providers not listed as approved in the COC, or by providers delivering services outside of the scope of their licenses, are not covered.
36. Non-network provider charges that are above the UMP allowed charge, even when the provider is paid at the out-of-area rate.
37. Organ donor coverage for anyone who is not a UMP enrollee, or costs of locating a donor (such as tissue typing of family members), except as described under "Organ Transplants" in the COC.
38. Organ transplant expenses not preauthorized by UMP.
39. Orthognathic surgery, or surgery to straighten or correct the jaw, except for a congenital anomaly in covered dependent child.
40. Orthoptic therapy (eye training) or vision services, except as described under "Vision Care (Routine)" in the COC.
41. Other insurance coverage—services or supplies are not covered if benefits are available under any automobile medical, automobile no-fault, workers' compensation, personal injury protection, commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if it covers medical treatment of injuries. (When we say "available," we mean that you could get services paid under another policy by applying for coverage.) However, UMP may advance payments to you with the expectation that UMP will be reimbursed from any settlement.
42. Physical exam—Any additional portion of a physical exam beyond what is covered by the preventive care benefit, even if required for employment, travel, immigration, licensing, or insurance and related reports.
43. Prescription drug charges over the UMP allowed charge, regardless of where purchased.
44. Provider administrative fees—Any charges for completing forms or copying records, except for records requested by UMP to perform retrospective utilization review.
45. Recreation therapy.
46. Residential treatment programs that are not solely for chemical dependency treatment or a mental health condition requiring inpatient care treatment (such as schools, wilderness programs, and behavioral programs for teenagers).
47. Services or supplies:
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member.
    - That are solely for comfort (except as described in "Hospice Care" in the COC).
    - For which you are not obligated to pay.
48. Sexual dysfunction or disorder diagnosis, counseling or treatment.
49. Sexual reassignment surgery, services, counseling, or supplies.
50. Skilled nursing facility services or confinement:
    - For treatment of mental health conditions or retardation.
    - When primary use of the facility is as a place of residence.

- When treatment is primarily custodial (see definition of "Custodial Care" in the COC.

51. Sterilization (reversal of voluntary vasectomy or tubal ligation).
52. TMJ (temporomandibular joint) disorder treatment, except as described under "TMJ (Temporomandibular Joint) Treatment" in the COC.
53. Tobacco cessation services, supplies, or medications, except as described under "Tobacco Cessation Program" in the COC.
54. Weight control, weight loss, and obesity treatment as follows:
    - **Non-surgical**: Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. UMP does not cover exercise programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services. Such treatment is not covered even if prescribed by a provider.
    - **Surgical**: Any surgery for obesity or morbid obesity, including any related medical services, drugs, or supplies. UMP does not cover gastroplasty, gastric stapling, gastric wrapping or banding, gastric bubble or balloon, intestinal bypass, or any other bariatric surgery, except under case management as described under "Obesity Surgery" in the COC. Removal of excess skin is not covered. Bariatric surgery will not be covered if you have had bariatric surgery within the last ten years, or if you have ever had this surgery covered under a PEBB plan.
55. Workers' compensation—UMP does not cover services or supplies if benefits are available under any workers' compensation or other similar type of program, insurance, or contract. (When we say "available," we mean that you could get services paid for under another policy by applying for coverage.)

If you have questions about whether a certain service or supply is covered, call UMP at 1-800-762-6004 (or 425-670-3000 in the Seattle area).

What the Managed-Care Plans Don't Cover:

The following services and supplies are excluded from all PEBB-sponsored managed-care plans. Plan-specific exceptions are noted. For further explanation of any exclusion, refer to the plan's certificate of coverage.

1. Services not provided by a plan-designated provider or obtained in accordance with the plan's standard referral and authorization requirements, except for emergency care or as covered under coordination of benefits provisions.
2. Non-participating providers are not covered inside or outside of the service area except for: emergencies; as specifically provided in the student eligibility section; or when otherwise specifically provided.
3. Experimental or investigational services, supplies, and drugs.
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports.
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health care coverage or for which the enrollee is not liable; services provided by a family member.
6. Drugs and medicines not prescribed by a plan-designated provider, except for emergency treatment.
7. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
8. Skilled nursing facility confinement or residential mental health treatment programs for mental health conditions, mental retardation, or for care which is primarily domiciliary, convalescent, or custodial in nature.
9. Conditions caused by or arising from acts of war.
10. Dental care including: orthognathic surgery (except for congenital anomalies), myofascial pain dysfunction (MPD), and dental implants.
11. Sexual reassignment surgery, services, and supplies.
12. Reversal of voluntary sterilization.
13. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization.

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General Medical Exclusions

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14. Services and supplies provided solely for the comfort of the enrollee, except palliative care provided under the "Hospice Care" benefit.
15. Coverage for an organ donor, unless the recipient is an enrollee of the plan.
16. Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies, or any bariatric surgery (such as gastroplasty, gastric banding, or intestinal bypass), regardless of co-morbidities, complications of obesity, or any other medical condition. **Exception:** The surgical exclusion noted above does **not** apply to Group Health Cooperative, Kaiser Permanente, or Regence pre-authorized, medically necessary bariatric surgery for treatment of adult morbid obesity as specifically set forth in each plan's Certificate of Coverage and Bariatric Management Criteria.
17. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
18. Orthoptic therapy (eye training); vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct complications.
19. Orthotics, except foot care appliances for prevention of complications associated with diabetes, which are covered.
20. Routine foot care.
21. Services for which an enrollee has a contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that the enrollee received double recovery for such services.
22. Any medical services or supplies not specifically listed as covered.
23. Direct complications arising from excluded services.
24. Pharmaceutical treatment of impotence or sexual dysfunction.
25. When Medicare coverage is primary, charges for services or supplies provided to enrollees through a "private contract" agreement with a physician or practitioner who does not provide services through the Medicare program.
26. Replacement of lost or stolen medications.
27. Recreation therapy.

How the Dental Plans Work

You have three dental plans to choose from:

Preferred Provider Organization (PPO)

- The ***Uniform Dental Plan*** (UDP), administered by Washington Dental Service (WDS), allows you the freedom to choose any dentist, but provides a higher reimbursement if your dentist contracts with WDS. The UDP *offers services in every county of Washington State*. Outside of Washington, services are reimbursed at a higher level than for services provided by non-PPO dentists in Washington**. Note:** UDP **does not issue** I.D. cards.

About Washington Dental Service

Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers several dental plans, including the Uniform Dental Plan (UDP) and DeltaCare. If you choose UDP or DeltaCare, be sure that you choose a WDS-contracting dentist who participates with your plan. Each plan maintains its own provider network.

Managed-Care Plans

- ***DeltaCare, administered by WDS***, requires selection of one of its network dentists when you enroll. **You must verify your dentist contracts with DeltaCare as WDS administers several types of dental plans, each with its own provider network.** This is important, as you could be responsible for costs if you receive care from a provider who is not in the DeltaCare network. *Providers are located* in Arlington*, Auburn, Bellevue, Bellingham, Bonney Lake, Bremerton, Burien, Des Moines*, Edmonds, Everett*, Gig Harbor, Kennewick, Kent, Kirkland*, Lakewood*, Lynnwood, Mill Creek, Mukilteo*, Newcastle, Olympia, Puyallup, Renton, Seattle, Shelton*, Shoreline, Spokane, Tacoma, Tukwila, Tumwater*, Vancouver , Wenatchee, Yakima, and Portland and Hillsboro (Oregon).

  **Not accepting new patients*

- ***Regence BlueShield Columbia Dental Plan***, with services provided by Willamette Dental Group (WDG), requires that you receive care from WDG dentists. Their *clinics are located* in Bellevue, Bellingham, Everett, Federal Way, Kennewick, Kent, Lakewood, Longview, Lynnwood, Olympia, Pullman, Puyallup, Renton, Richland, Seattle, Silverdale, Spokane (Northpointe and South Hill), Tacoma, Tumwater, Vancouver (East Vancouver, Hazel Dell, and Mill Plain), Wenatchee, and Yakima.

Please note: Since dentist and clinic participation with the dental plans can change, **please contact the dental plans to verify dentists and clinic locations.**

Is a Managed-Care Dental Plan Right for You?

The table on the next page briefly compares the features of the UDP and the managed-care dental plans. Before enrolling in a managed-care dental plan, it is important to answer the following questions:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB state of Washington employee.)
- Am I willing to travel for services if I select a dentist in another service area?
- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If your answer to these questions is yes, you may want to consider enrolling in a managed-care dental plan.

For full coverage provisions, including limitations and exclusions, refer to a PEBB certificate of coverage (available through the dental plans).

Please note: Benefits for emergency care received out of the plan's service area; missed appointment charges; and the number of exams, x-rays, cleanings, and other procedures allowed in a certain time period vary by plan. Contact the plans directly for details. (Dental plan phone numbers are listed in the front of this booklet.)

If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out how they cover your continuous dental treatment if you enroll in their plan.

Dental Benefits Comparison

(For more details on benefits and exclusions, contact the plans.)

	Preferred provider organization: Uniform Dental Plan	**Managed-care dental plans:** DeltaCare Regence BlueShield Columbia Dental Plan
Annual deductible	Enrollee pays $50 per person/ $150 per family, except for diagnostic and preventive	No deductible
Annual maximum	$1,500 plan reimbursement per person; except as otherwise specified for orthodontia, nonsurgical TMJ, and orthognathic surgery	No general plan maximum
Dentures	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	Enrollee pays $140 copay, complete upper; $40 copay, complete reline (chairside)
Endodontics (root canals)	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Enrollee pays $50 copay, anterior; $100 copay, molar
Nonsurgical TMJ	70%; $500 lifetime maximum (dental plan payment)	70%; $500 lifetime maximum (dental plan payment)
Oral surgery	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Extraction of erupted teeth: *DeltaCare,* enrollee pays $10 copay; *Regence BlueShield Columbia Dental Plan,* $0 copay
Orthodontia	50%; $1,500 lifetime maximum (dental plan payment)	Maximum enrollee copay per case: *DeltaCare,* $1,500; *Regence BlueShield Columbia Dental Plan,* $1,200
Orthognathic surgery	70%; $5,000 lifetime maximum (dental plan payment)	70%; $5,000 lifetime maximum (dental plan payment)
Periodontic services	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Enrollee pays $75 copay, gingivectomy, or gingivoplasty per quadrant; $100 copay, osseous surgery per quadrant
Preventive/ diagnostic	100%, PPO; 90%, out of state; 80%, non-PPO (dental plan payment)	100% (dental plan payment)
Restorative crowns	50%, PPO and out of state; 40%, non-PPO (dental plan payment)	Porcelain to metal crown: *DeltaCare,* enrollee pays $175 copay; *Regence BlueShield Columbia Dental Plan,* $140 copay. Full cast metal crown: *DeltaCare,* $150 copay; *Regence BlueShield Columbia Dental Plan,* $140 copay
Restorative fillings	80%, PPO and out of state; 70%, non-PPO (dental plan payment)	Amalgam restorations (fillings), two surfaces: *DeltaCare,* enrollee pays $10 copay; *Regence BlueShield Columbia Dental Plan,* $0 copay

Blue ink indicates information only for subscribers who have dental coverage.

General Dental Exclusions

Regence BlueShield Columbia Dental Plan

The following services are not covered:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
3. Application of desensitizing medicaments.
4. Services or supplies that the plan determines are experimental or investigative.
5. Any drugs or medicines, even if they are prescribed, except as stated in the Prescription Drug Program benefit. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
6. General anesthesia, intravenous, and inhalation sedation, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.
7. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:

   a. A hospital setting for the dental care must be medically necessary.

   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.

   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
8. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
9. Services for accidental injury to natural teeth when evaluation of treatment and development of a written treatment plan is performed more than 30 days from the date of the injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.
10. Expenses incurred after termination of coverage, except expenses for:

    a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.

    b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.

    c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
11. Missed appointments.
12. Completing insurance forms or reports, or for providing records.
13. Habit-breaking appliances, except as specified under the orthodontia benefit.
14. Full-mouth reconstruction, or dental implants, except when dental implants are provided through Willamette Dental Implant Program, or replacement of sound fillings. (Replacement of sound fillings will not be covered unless recommended by a licensed dentist; preauthorization is required.)

General Dental Exclusions

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15. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist, or physician, as specified.
16. Services or supplies that are not listed as covered.
17. Treatment of congenital deformity or malformations.
18. Orthodontic treatment, orthognathic treatment, and treatment of temporomandibular joint (TMJ) disorders that are not authorized in advance by the plan.
19. Replacement of lost or broken dentures or other appliances.
20. Services for which an enrollee has contractual rights to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's, or other no-fault insurance.

DeltaCare

The following services are not covered:

1. General anesthesia, intravenous, and inhalation sedation, and the services of a special anesthesiologist, except that coverage will be provided for general anesthesia services in conjunction with any covered dental procedure performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.
3. Services for injuries or conditions which are compensable under workers' compensation or employers' liability laws, and services which are provided to the eligible person by any federal, state, or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion without sensitivity and restorations for malalignment of teeth.
5. Application of desensitizing agents.
6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/ observation.
7. Dental services performed in a hospital and related hospital fees. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
   a. A hospital setting for the dental care must be medically necessary.
   b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
   c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

   If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage.
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility, except for orthodontic services.
11. Cysts and malignancies.
12. Laboratory examination of tissue specimen.

Blue ink indicates information only for subscribers who have dental coverage.

13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.
14. Cases which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
15. Prophylactic removal of impactions (asymptomatic, nonpathological).
16. Specialist consultations for non-covered benefits.
17. Implant placement or removal; however, crowns placed on implants will be covered.
18. Orthodontic treatment which involves therapy for myofunctional problems, TMJ dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities.
19. All other services not specifically included on the patient's copayment schedule as a covered dental benefit.
20. Treatment of fractures and dislocations to the jaw.
21. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).
22. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare (WDS) or as cited under "Emergency Care or Urgent Care" in DeltaCare's certificate of coverage.

Uniform Dental Plan

General Limitations

1. Dentistry for cosmetic reasons is not a covered benefit. Cosmetic services include, but are not limited to laminates, veneers, or tooth bleaching.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such excluded procedures include restoration of tooth structure lost from attrition, abrasion, erosion, and malalignment of teeth.
3. General anesthesia, intravenous, and inhalation sedation are not a covered benefit except that coverage will be provided:
    a. When in conjunction with covered oral surgery, endodontic and periodontal surgical procedures; and
    b. For general anesthesia services in conjunction with any covered dental procedures performed in a dental office if such anesthesia services are medically necessary because the enrollee is under the age of 7, or physically or developmentally disabled.

General Exclusions

In addition to the specific exclusions and limitations stated elsewhere in the booklet, UDP does not provide benefits for:

1. Application of desensitizing medicaments.
2. Services or supplies that the Uniform Dental Plan determines are experimental or investigative. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/ observation.
3. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient-management drugs, such as premedication and nitrous oxide.
4. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:
    a. A hospital setting for the dental care must be medically necessary.
    b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.
    c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by Washington Dental Service. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

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General Dental Exclusions

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If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those services performed by a participating dental provider, up to the available benefit maximum. provided at the same percentage rate as those services performed by a participating dental provider, up to the available benefit maximum.

5. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.
6. Services for accidental injury to natural teeth when evaluation of treatment and development of a written plan is performed more than 30 days from the date of the injury. Treatment must be completed within the time frame established in the treatment plan unless delay is medically indicated and the written treatment plan is modified.
7. Expenses incurred after termination of coverage, except expenses for:
   a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
   b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
   c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
8. Missed appointments.
9. Completing insurance forms or reports, or for providing records.
10. Habit-breaking appliances, except as specified under the orthodontia benefit.
11. Full-mouth restoration or replacement of sound fillings. (Replacement of sound fillings will not be covered unless recommended by a licensed dentist, and preauthorization is required.)
12. Charges for dental services performed by anyone who is not a licensed dentist, registered dental hygienist, denturist, or physician, as specified.
13. Services or supplies that are not listed as covered.
14. Treatment of congenital deformity or malformations.
15. Replacement of lost or broken dentures or other appliances.
16. Services for which an enrollee has a contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's, or other no-fault insurance.
17. In the event an eligible enrollee fails to obtain a required examination from a Washington Dental Service-appointed consultant dentist for certain treatments, no benefits will be provided for such treatment.

Washington Dental Service shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the contract.

Washington State
Health Care Authority
Public Employees Benefits Board

www.pebb.hca.wa.gov